WWW.TOURMED.CA
Telephone : 1 877 344-8398
Fax : 1 819 377-6069

247 Thibeau Blvd.
Trois-Rivières (Québec) G8T 6X9

COLLECT COLLECT Total

CLAIM FORM

Insured by LS insurance company Travel

Group Out-of-Province Travel Medical Emergency Insurance

This claim form is mandatory whether you have incurred out of pocket expenses or not.

This claim form must be completed, signed and returned to the Insurer as soon as possible but no later than 90 days after your return in your province of residence.

If you need assistance in completing this claim form, our Claims team will answer your questions from Monday to Friday, 8:30AM to 5:00PM EST. Call toll free 1-877-344-8398 or collect 1-819-377-1777.

PLEASE SUBMIT THE APPLICABLE SUBSTANTIATING DOCUMENTATION

- Original detailed invoices or receipts. Please note that photocopies or cash/cashier receipts are not accepted.
- **A proof*** of your **Departure date** from your province of residence is mandatory.
  (* boarding pass, plane ticket, credit card receipt, confirmation obtained at the border/immigration).

PARTICIPANT'S STATEMENT

Name of the Insured and address where to send the refund. Desired currency: CAD ☐ USD ☐

_____ _____
First name Last name Contract Number

_____
No. Street apt. # City Province Postal Code

_____ Telephone: (_____) _____ Date of birth: _____ / _____ / _____
Government Health Insurance Number dd mm yy

Email Address: _____

Name of the employer: _____

Are you covered by any other travel insurance (private, group, Medicare, credit card)? YES ☐ NO ☐

Company : _____ Policy Number : _____ Telephone : (_____) _____

DEPENDANTS - to be completed if the claim is for a Dependant

_____
First Name Last Name

Date of Birth: _____ / _____ / _____ Relationship with Participant: _____
dd mm yy

_____
Signature of the Dependant (if has reached age of majority)

If the claim is for a Dependant child:

Is he/she married? YES ☐ NO ☐ Does he/she usually live with the Participant? YES ☐ NO ☐

Is he/she a student in a Cegep (college) or university? YES ☐ NO ☐

If yes, name and address of the educational institution: _____

_____

CLAIM EXPENSES

Provide brief description of the expenses and indicate amounts incurred. (If you need more space, please attach a separate sheet).

Name of medical services provider (or any type of services incurred)	Date of service received (dd/mm/yy)	Amount billed	Amount paid by you	Currency
		$	$	
		$	$	
		$	$	
		$	$	
		$	$	
		$	$	

CLAIM FOR MEDICAL EXPENSES (PLEASE ANSWER ALL QUESTIONS)

a) Please check the appropriate box: Sickness ☐ Accident ☐ Other ☐ Please specify: _____

b) Treatment received in: Office/clinic ☐ Emergency Room of a hospital ☐ Hospital ☐

c) Have the expenses been incurred during a business trip? YES ☐ NO ☐

d) Please provide dates and brief details about this claim.

_____

_____

_____

_____

e) In the past, have you ever been treated for those symptoms or illnesses? YES ☐ NO ☐

If YES, please provide the dates and places of consultation.

_____

_____

f) Please provide name and contact information of your family doctor in Canada.

☐ I don't have a family doctor

Name: _____ Telephone: _____

Address: _____

CERTIFICATION AND AUTHORIZATION

I hereby assign to LS-Travel Insurance Company (the Insurer) any benefits obtained from other sources for losses covered under this policy. I also direct these sources to forward payment to the Insurer for my claims submitted by the Insurer with regard to these losses and authorize all parties above to exchange and share information to facilitate the claims process.

I hereby authorize any physician, hospital, other health care practitioners, medical care facilities, insurance carriers, any other person who has attended or examined me and any other source involved in this claim to provide the Insurer any medical and other information needed to process the claim. I also consent that such information be shared with other sources for the Insurer to be able to coordinate the payment of benefits when applicable.

I certify that I have no other insurance coverage than the ones mentioned in this claim form.

I understand that the making of false or fraudulent statement in connection with a claim for benefits will render the insurance policy null and void.

I certify that the statements given in the making of this claim are complete, true and correct to the best of my knowledge.

A photocopy, facsimile or electronic copy of this authorization shall be considered as effective and valid as the original.

Signature of the claimant spouse (if applicable): _____ Date: _____

Signature of the Participant: _____ Date: _____